STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085010	A. BUILDING _____ B. WING _____	C 03/04/2019

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F 000	INITIAL COMMENTS An unannounced complaint survey was conducted at this facility from February 28, 2019 through March 4, 2019. The deficiencies contained in this report are based on observations, interviews, review of residents' clinical records and review of other facility documentation. The facility census on the first day of the survey was 125. The survey sample totaled 21 (twenty one) residents. Abbreviations/Definitions used in this report are as follows: NHA - Nursing Home Administrator; DON - Director of Nursing; ADON - Assistant Director of Nursing; AD - Activity Director; RN - Registered Nurse; LPN - Licensed Practical Nurse; UM - Unit Manager; MD - Medical Doctor; RNAC - Registered Nurse Assessment Coordinator; CNA - Certified Nurse's Aide; RD - Registered Dietitian; NP - Nurse Practitioner; PT - Physical Therapist; FMD - Facility Maintenance Director; SW - Social Worker; ADLs (Activities of Daily Living) - activities such as bathing and dressing; ADL Self-Performance: Extensive Assistance - resident involved in activity, staff provide weight-bearing support; Limited Assistance - resident highly involved in activity, staff provide guided movement of limbs	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 03/26/2019

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F 000	Continued From page 1	F 000		

or other non-weight bearing assistance;
Supervision - oversight, encouragement or cueing;
Total Dependence - full staff performance every time activity performed;
Antipsychotic - drug to treat psychosis and other mental/emotional conditions;
BIMS (Brief Interview for Mental Status) - test to measure thinking ability with score ranges from 0 to 15.
13-15 Cognitively Intact
8-12 Moderately Impaired
0-7 Severe Impairment
Cognitive function - mental abilities;
Cognitively intact - able to make own decisions;
Continence - control of bladder and bowel function;
Debility - decline in function;
Dementia - loss of mental functions such as memory and reasoning that is severe enough to interfere with a person's daily functioning;
Etc. (etcetera) - and so forth;
Hoyer lift - a mechanical device designed to lift patients safely;
Incontinence - loss of control of bladder and bowel function;
Always incontinent - no episodes of continence;
Frequently incontinent - 7 or more episodes of incontinence, but at least one episode of continent voiding during a 7 day period;
Occasionally incontinent - less than 7 episodes of incontinence;
LTC - long term care;
MAR - Medication Administration Record;
MDS (Minimum Data Set) - standardized assessment used in nursing homes;
Moderate Cognitive Impairment - decisions poor, cues / supervision required;
Paralysis - inability to move (and sometimes to

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F 000	Continued From page 2 feel anything) in part or most of the body, typically as a result of illness, poison, or injury; Perimeter mattress - mattress with raised sides; Pressure ulcer (PU) - sore area of skin that develops when blood supply to it is cut off due to pressure of laying / sitting on it; Psychosis - loss of contact/touch with reality; Psychotic - loss of contact ability to think rationally; Psychotropic - medication capable of affecting the mind, emotion, and behavior; Quadriplegia - unable to move from the neck down (arms, legs, torso); Restorative - having the ability to restore health, strength, or a feeling of well-being; Severe Cognitive Impairment - unable to make own decisions; Stroke - reduced blood supply or bleeding in the brain.	F 000		
F 558 SS=D	Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3) §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is not met as evidenced by: Based on observations, interviews, and record reviews it was determined that for one (R14) out of four sampled residents reviewed for investigation of preferences, the facility failed to accommodate R14's preferred bathing schedule. Findings include: 11/2/17 - R14 was admitted to the facility.	F 558	A. R14 was discharged from facility 12/18/18. B. Current residents or resident representative interviewed for shower preferences. Plans of care and Point of Care were updated accordingly.	4/17/19

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F 558	Continued From page 3 12/18/18 - A care plan for activities of daily living stated, "Resident/Patient requires assistance with bathing." Review of the CNA shower binder documented that R14 was on the shower list scheduled for preferred showers two times per week. Review of CNA documentation revealed: October 2018 - no documented showers. November 2018 - no documented showers. December 2018 - no documented showers. 3/1/19 5:25 PM - During an interview with E2 (DON), it was confirmed that there was lack of evidence for R14 being showered in October, November, and December. Review of other residents' charts revealed a task for bathing and a separate task for tub bath or shower. E2 reported that sometimes the CNA's document showers in both of the tasks or in just one task with the code for a shower. R14's record did not include both tasks. E2 stated,"we all remember her getting showers, but the task for showering is not in her records". E2 stated that he/she did not know why the task for showering was not included in R14's record. 3/4/19 9:15 AM - During an interview with E2 (DON), it was confirmed that E2 was unable to provide additional documentation to show that R14 received his/her scheduled showers. E2 stated there was documentation for R14 receiving bed baths, but not a tub bath or shower. 3/4/19 10:35 AM - During an interview with E8 (CNA), E8 stated, "there is two different places in the CNA's tasks to document showers, tub and/or	F 558	C. A Root Cause Analysis (RCA) was completed on 3/20/19 to determine underlying causes for shower preferences not being accommodated. As a result of the RCA, education is being provided for nurses & CNAs on OPS200 Accommodation of Needs, including but not limited to shower/bathing preference (attachment A) by the Nurse Practice Educator (NPE) or designee. Education will be completed on or before 4/17/19. D. The Center Nurse Executive (CNE) or designee will complete daily audits (attachment B) on 10% of the resident population for showers being completed per preference until 100% compliance is achieved on 3 consecutive reviews, then audits will be completed three times per week until 100% compliance is achieved on 3 consecutive reviews, then weekly until 100% achieved on 3 consecutive reviews, then monthly until 100% compliance achieved on 3 consecutive reviews. Results of audits will be presented to the Quality Assurance Performance Improvement (QAPI) Committee for review & recommendations.	

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F 558	Continued From page 4 bed baths." One task labeled bathing was included in R14's record and E8 confirmed that tub/shower can be documented in the bathing task. 3/4/19 10:45 AM - During an additional interview with E8 (CNA), it was confirmed that E8 could not identify a shower being given by the documentation that E2 (DON) provided to the surveyor. E8 also confirmed that there is another section of CNA's tasks specifically for tub or shower and it could not be located in R14's record. The facility failed to accommodate R14's preference for having two showers a week. Findings were reviewed with E1 (NHA), E2 (DON) and E9 (ADON) on 3/4/18 during the exit conference beginning at 2:45 PM.	F 558		
F 584 SS=D	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk.	F 584		4/17/19

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F 584	Continued From page 5 (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined that the facility failed to maintain a clean, comfortable and homelike environment, free of urine odor for two (R3 and R19) out of 21 sampled residents. Findings include: 1. 3/1/19 at 5:30 AM- During an observation of R3's electric wheelchair in the Activity Room, there was a pungent aroma of stale urine. The foul smell was most intense from the wheelchair cushion. 2. 3/1/19 at 8:30 AM- During routine observations	F 584	A. R3 & R19 wheelchair cushions replaced on 3/4/19. B. Rounds were completed on current residents and wheelchair cushions are free from urine odors. C. A RCA was completed on 3/20/19. As a result of the RCA, the inside of the wheelchair cushions have been covered. In addition, staff education being provided on or before 4/17/19 regarding facility expectation for maintaining a clean,	

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F 584	Continued From page 6 on the East - South Wing, a foul smell of urine was noticeable in the hall outside of R19's room. The foul smell was most intense from R19's wheelchair cushion. R19 was in bed. 3/1/19 at 10:15 AM - During an interview with E20 (Environmental Manager) and E21 (Assistant Environmental Manager), E20 stated that he/she had personally washed R3 and R19's wheelchairs outside on Saturday (6 days ago) and the facility had scheduled cleaning of all wheelchairs every Monday at 3:00 AM. Additionally, they try to clean as many wheelchairs as possible every Friday. When asked if the seat cushions were routinely cleaned, E20 said the exterior zippered cushion cover was cleaned each time the wheelchair is cleaned, but the inside cushion is not cleaned. 3/4/19 at 1:00 PM - During an interview with E19 (RN, Unit Manager), after discussing that R3 and R19's wheelchair seat cushions had a foul urine odor, despite cleaning, E19 stated that he/she would have the cushions replaced. These findings was reviewed with E1 (NHA), E2 (DON) and E9 (ADON) on 3/4/19 during the exit conference beginning at 2:45 PM.	F 584	comfortable and homelike environment, free of urine odor. D. The Center Executive Director (CED) or designee will complete daily audits (attachment C) on 10% of the resident population with wheelchair cushions until 100% compliance for urine free odor is achieved on 3 consecutive reviews. Then audits will be completed weekly until 100% achieved on 3 consecutive reviews, then monthly until 100% compliance achieved on 5 consecutive reviews. Results of audits will be presented to the QAPI Committee for review & recommendations.	
F 585 SS=D	Grievances CFR(s): 483.10(j)(1)-(4) §483.10(j) Grievances. §483.10(j)(1) The resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been	F 585		4/17/19

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F 585	Continued From page 7 furnished, the behavior of staff and of other residents, and other concerns regarding their LTC facility stay. §483.10(j)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph. §483.10(j)(3) The facility must make information on how to file a grievance or complaint available to the resident. §483.10(j)(4) The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy to the resident. The grievance policy must include: (i) Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system; (ii) Identifying a Grievance Official who is	F 585		

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F 585	Continued From page 8 responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations; (iii) As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated; (iv) Consistent with §483.12(c)(1), immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law; (v) Ensuring that all written grievance decisions include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued; (vi) Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement Organization, or local law enforcement agency confirms a violation for any of these residents'	F 585		

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F 585	Continued From page 9 rights within its area of responsibility; and (vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision. This REQUIREMENT is not met as evidenced by: Based on record review, interviews, and review of other facility documentation, it was determined that the facility failed to ensure that complaints / grievances received by the facility included prompt efforts to resolve problems for two (R20 and R21) out of five residents investigated for grievances. Findings include: Review of the facility's Grievance and Concerns Policy (last revised 3/1/18) stated: -The procedure for voicing grievances/concerns included the right to file grievances orally (meaning spoken) or in writing. -Upon receipt of the grievance/concern, the "Grievance/Concern Form" will be initiated by the staff member receiving the concern and documented on the "Grievance/Concern Log". 1/7/19- Review of the facility's Resident Council meeting minutes provided by E3 (Activities Director) revealed that R20 and R21 voiced concern that a smell was coming from room 127B. The response from the nursing department was that room 127 was checked at various times of the day for odors. As odors arise, they will be addressed and remedied. Bathing/hygiene was discussed with one resident. 2/7/19: Responses from R20 or R21 stated their concerns were addressed and room 127B was cleaned.	F 585	A. Grievance completed & resolved for R20 & R21. Room 127B thoroughly cleaned and R20 & R21 with no further concerns with odor with grievance follow up on 3/21/19. B. Current grievances being logged on grievance log upon receipt of voiced or written grievances. Grievances 3/18/19 to date, including Resident Council minutes from March 2019 were reviewed to determine prompt efforts to resolve grievances/concerns were addressed and entered into the grievance log. C. A Root Cause Analysis (RCA) was completed 3/20/19. As a result of the RCA, education for all staff on OPS204 Grievance/Concern policy (attachment D) is being completed by the Nurse Practice Educator (NPE) on or before 4/15/19. In addition, a new process for discussing grievances in the morning clinical meetings by Social Services was initiated to determine grievances/concerns are logged & resolved promptly. D. The Center Executive Director (CED) or designee will monitor the Grievance/Concern Log (attachment E) weekly to determine prompt documentation and resolution of	

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F 585	Continued From page 10 2/7/19 - 2/28/19- Review of the facility's Grievance Log revealed no resident concerns from R20 or R21 about foul urine odors. 2/28/19 at 1:00 PM- R20 approached this surveyor and stated, "I have a problem you can help me with. There is a rank urine smell constantly coming from the room (R19's room) across the hall from my room. The smell is so bad it makes me nauseated. I have to barricade myself in my room by closing my door and lying towels at the bottom of the door to try to block the smell." When asked if he/she has told the staff about this odor, R20 said yes many times. When asked when and who he/she told, R20 said housekeeping several times in the past couple of weeks. R20 stated that staff responds that they are aware of the odor and do not know what else to do about it. 2/28/19 - 3/4/19- During observations in the East - South hall, a foul urine odor smell was coming from R19's room. R19 was in bed during all of these observations: -2/28/19 at 1:00 PM, 3:00 PM and 5:00 PM; -3/1/19 at 6:00 AM, 8:30 AM, 9:30 AM, 10:30 AM and 1:30 PM; -3/4/19 at 9:30 AM, 11:30 AM and 12:45 PM. 3/1/19 at 7:30 AM- Interview with R20 confirmed that he/she stated the foul urine odor from R19's room was resolved after the facility cleaned the room, but it only lasted for about a day. R20 stated the odor came back and thinks R19 is often incontinent and staff do not clean and change his/her briefs enough. 3/1/19 at 9:00 AM- Interview with E22 (housekeeper) confirmed that R20 had	F 585	patient/resident grievances/concerns for 12 weeks. The CED or designee will also review monthly Resident Council minutes for prompt documentation and resolution of patient/resident grievances/concerns until 100% compliance achieved for concerns identified on Grievance/Concern Log. Results of audits will be presented to the QAPI Committee for review & recommendations.	

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F 585	Continued From page 11 complained about the urine order from R19's room in the past two weeks. 3/1/19 at 10:00 AM- Interview with E23 (housekeeper) confirmed that R20 had complained about the urine order from R19's room in the past two weeks. 3/4/19 at 12:30 PM: Interview with R21 stated the odor returned after 2/7/19 when the facility cleaned the room. R21 confirmed that he/she complained to E24 (LPN) last week of the continuing foul odor from R19's room, that it is "so foul it makes me gag." 3/4/19 at 1:00 PM - During an interview, E19 (RN, Unit Manager) confirmed ongoing complaints of foul urine odor from R19 and R19's room. E19 stated that R19 has increased dementia and at times, refuses to wear incontinent briefs and permit hygiene, but they will have the wheelchair cushion replaced. Findings were reviewed with E1 (NHA), E2 (DON) and E9 (ADON) on 3/4/19 during the exit conference beginning at 2:45 PM.	F 585		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the	F 657		4/17/19

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F 657	Continued From page 12 resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on interviews and record review, it was determined that for one (R11) out of 21 sampled residents reviewed, the facility failed to review and revise R11's care plan for preferred bathing. Findings included: 10/21/17 - R11 was admitted to the facility. 10/21/17 - R11's care plan for activities of daily living did not include R11's twice per week complete bed bath preference. 3/1/19 - R11 was documented in the shower book for bathing two times a week. 3/1/19 1:30 PM - During an interview, R11 revealed the preference of receiving a bed bath twice a week in place of a scheduled shower. R11 stated, "I do not want to go to the shower room, I	F 657	A. R11 Activities of Daily Living (ADL) care plan was revised to reflect current preference for bathing. B. Current residents' ADL care plans were reviewed and revised as necessary to reflect bathing preference. C. A Root Cause Analysis (RCA) was completed 3/20/19. As a result of the RCA, education on OPS416 Person Centered Care Plan policy (attachment F) is being completed by the Nurse Practice Educator or designee for licensed nurses on or before 4/17/19. D. The CNE or designee will complete daily audits (attachment B) on 10% of the weekly scheduled care plans to determine	

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F 657	Continued From page 13 prefer a complete bed bath twice a week in place of the shower schedule." R11 stated, "the shower room is too cold" and due to the paralysis of his/her legs, R11 had "slipped off the shower chair onto the floor and was afraid that it would happen again." R11 stated that after the fall, he/she requested that staff provide complete bed baths on scheduled shower days. The facility failed to review and revise R11's activities of daily living care plan to include R11's preference for a complete bed bath twice a week. Findings were reviewed with E1 (NHA), E2 (DON) and E9 (ADON) on 3/4/18 during the exit conference beginning at 2:45 PM.	F 657	ADL care plans reflect their preferred bathing mode until 100% compliance is achieved on 4 consecutive reviews. Then audits will be completed monthly until 100% compliance achieved on 2 consecutive reviews. Results of audits will be presented to the QAPI Committee for review & recommendations.	
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined that the facility failed to assess two (R7 and R5) out of four residents reviewed for falls, after a fall. For R7, the facility failed to complete thorough neurological assessments on 13 occasions when pupil response was not evaluated. For R5, the facility failed to ensure the resident was assessed by a nurse prior to lifting	F 684	A. R5 was discharged from the facility on 10/3/18. R7 remains at facility and currently has medical documentation that pupil checks cannot be completed on neurological assessments due to visual impairment. B. Falls for current residents reviewed to	4/17/19

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F 684	Continued From page 14 the resident from the floor and returning him/her to bed. Findings include: Cross Refer F689, example #2 1. Review of R7's clinical record revealed: 1/21/19 (5:30 PM) - R7 was found on the floor in the resident's room and neurological assessments were to be conducted every 30 minutes for four times, every hour for four times and every 4 hours for four times ending on 1/22/19 at 3:30 PM. Neurological assessments can determine side effects of a head injury. Review of the neurological assessments revealed R7's pupil response (shining light in eye and see how fast the pupil constricts, gets small) was not assessed for any of the 13 assessment times. 3/1/19 (8:46 AM) - During an interview, E5 (UM) confirmed R7's lack of pupil assessments. 2. Cross Refer F689, example #3 9/23/18 6:38 PM - E24 (RN) stated in the progress notes that R5's daughter approached him/her at the nurses station, stating that R5 was dropped with the sit to stand lift after lunch, the nurse never came in to assess R5, and the family was upset. The facility's follow-up investigation revealed the following: -E24 (RN) statement: On 9/23/18 at 6:34 PM, R5's daughter approached me (E24) stating that R5 told her he/she slipped out of the sit to stand lift at 1:00 PM today and wanted to know why a nurse never came to assess R5. There was no	F 684	determine neurological assessments being completed per policy. C. A Root Cause Analysis (RCA) was completed 3/20/19. As a result of the RCA, education on NSG204 Neurological Assessment (attachment G) being completed by Nurse Practice Educator (NPE) or designee for licensed nurses. Education on OPS100 Accidents/Incidents (attachment H) being completed by NPE or designee for licensed nurses & CNAs. In addition, a new process was developed initiating a Falls Committee that reviews all falls weekly. The process will begin prior to 4/17/19. D. The Center Nurse Executive (CNE) or designee will complete audits (attachment I) of all falls for following fall protocol procedures weekly until 100% compliance achieved for 3 consecutive months. Results of audits will be presented to the QAPI Committee for review & recommendations.	

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F 684	Continued From page 15 documentation in the medical record and I (E24) did not get that information in report from day shift nurse... R5 stated that two CNAs had him/her in the sit to stand and he/she slipped out of it and landed on his/her bottom on one of the CNAs feet. One of the CNAs left to get a third CNA, and the three CNAs picked him/her up off the floor. E24 asked R5 if they used a hoyer lift. R5 said no - one CNA lifted under each shoulder and picked up the legs and put him/her back in bed. R5 also stated that one of the CNAs said she was not comfortable using the sit to stand and that she would never use one again- that she would only use a hoyer lift. E24 assessed R5 at this time and found no apparent injuries. 9/24/18- The facility provided education to the three CNAs involved in the fall (E14, E17 and E25) that both a fall and lowering a resident in a downward position need to be reported to a nurse immediately, so the resident can be assessed. This finding was reviewed with E1 (NHA), E2 (DON) and E9 (ADON) on 3/4/19 during the exit conference beginning at 2:45 PM.	F 684		
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives	F 686		4/17/19

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F 686	Continued From page 16 necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, record review, interview, and review of facility policies, it was determined that for one (R1) out of three residents reviewed for pressure ulcer prevention, the facility failed to ensure that a resident at risk for pressure ulcers received the necessary treatment and services, consistent with professional standards of practice. The facility failed to consistently turn R1, a dependent resident at risk for pressure ulcers, side to side to prevent skin breakdown as per the plan of care. Findings include: The facility's policy titled Skin Integrity Management, last revised 11/28/16, stated the practice standards included to develop comprehensive, interdisciplinary plan of care including prevention and wound treatments, as indicated, implement pressure ulcer prevention for identified risk factors, and to implement skin/wound care guidelines as applicable. 3/10/16 (last revised)- R1's care plan for being at risk for skin breakdown due to decreased mobility and quadriplegia included the intervention (initiated 7/17/15) to turn and/or reposition and check skin every 2 hours. 12/12/18- A quarterly MDS assessment documented that R1 required extensive assistance with two or more staff assistance for bed mobility (how resident moves to and from a lying position, turns side to side, and positions body while in bed).	F 686	A. R1 remains in the facility and is receiving turning and repositioning per the residents plan of care. B. Current residents with high risk for skin breakdown, (high risk residents identified by using the Braden Scale), have been identified & visual rounding by the Interdisciplinary Team has been implemented to determine compliance with repositioning. C. A Root Cause Analysis (RCA) was completed 3/21/19. As a result of the RCA, it was determined education on prevention of pressure ulcers, including but not limited to following the residents' plan of care for repositioning by the certified nursing assistants (CNAs) and oversight by the licensed nurse was needed. Education will be completed by the Nurse Practice Educator (NPE) to all licensed nurses & CNAs on or before 4/17/19. D. The Center Nurse Executive (CNE) or designee will complete daily observation audits (attachment J) on 10% of the residents requiring turning & repositioning until 100% compliance for turning & repositioning has occurred on 3 consecutive reviews. Then audits will be completed weekly until 100% achieved on	

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F 686	Continued From page 17 2/28/19 - 3/4/19- For all observations during the survey, R1 was in bed lying on his/her back. There were no observations of R1 positioned on either side nor out of bed. The following observations were made: -2/28/19 at 8:00 AM, 9:06 AM, 10:45 AM, 1:00 PM, 3:00 PM, and 5:00 PM. -3/1/19 at 6:00 AM, 8:30 AM, 9:30 AM, 10:30 AM, and 1:30 PM. -3/4/19 at 9:30 AM, 11:30 AM, and 12:45 PM. 3/4/19 at 1:00 PM - During an interview with E19 (RN, Unit Manager), the observations of R1 lying on his/her back in bed were reviewed. E19 stated that R1 usually does not want to get out of bed, but she was unaware of R1 refusing to turn. E19 confirmed that R1 should be turned every 2 hours while in bed, and stated he/she will address this with the CNAs immediately. Findings were reviewed with E1 (NHA), E2 (DON) and E9 (ADON) on 3/4/19 during the exit conference beginning at 2:45 PM.	F 686	3 consecutive reviews, then monthly until 100% compliance achieved on 5 consecutive reviews. Results of audits will be presented to the QAPI Committee for review & recommendations.	
F 689 SS=G	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, record review and	F 689	A. R5 was discharged from the facility	4/17/19

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F 689	Continued From page 18 interview, it was determined for three (R18, R7 and R5) out of four residents investigated for falls, the facility failed to: - Provide adequate supervision; - Conduct thorough fall investigations, including obtaining witness statements to identify hazards and identify interventions to reduce hazards; - Ensure the correct mechanical lift was used during a transfer; and - Ensure the licensed nurse immediately conducted a post fall assessment. For R18, who had severe cognitive impairment, poor safety awareness, and resided in the locked Dementia unit, the facility failed to provide adequate supervision. R18 sustained 9 falls between April 2018 - November 2018. R18 sustained harm when he/she broke his/her wrist from a fall on 8/27/18 and had a broken spine from a fall on 11/8/18. For R7, who had moderate cognitive impairment, impulsive behavior, poor safety awareness, and resided in the locked Dementia unit, the facility failed to provide adequate supervision. R7 sustained 19 falls between July, 2018 - February, 2019. R7 sustained harm when he/she received a 7 cm laceration on the left ear on 9/20/18, requiring treatment in the emergency department. For R7 and R18, the facility failed to conduct thorough fall investigations with root cause analyses and they lacked witness statements. For R5, the facility failed to utilize the correct mechanical lift and failed to ensure the licensed nurse assessed the resident before transfer from the floor post fall. Findings include: Review of the facility's Guidelines for Managing a Fall (dated 2011) revealed that staff was to remain calm and stay with the patient. Call for	F 689	10/3/18. R18 was discharged from the facility 11/15/18. R7 care plan and task were reviewed and updated to include a toileting care plan on 3/19/19. B. Care plans for current residents at high risk for falls were reviewed and revisions to prevent accidents were completed. Specific interventions for residents with supervision are in place on the residents' care plan & tasks as indicated. Current resident lift assessments were completed to determine the appropriate lift device sticker is placed outside the residents door on name card/room number. When resident transfer status is changed the nurse on the unit will be responsible to change the sticker outside the door. A thorough assessment and fall investigation is being completed on all residents experiencing falls. C. A Root Cause Analysis (RCA) was completed on 3/21/19. Changes implemented as a result of the RCA include: An Interdisciplinary Falls Committee was established for post fall review of residents RCA, incident investigation and care plan revision as needed. The Nurse Practice Educator (NPE) or designee will educate licensed nurses & CNAs on the Safe Resident Handling Policy and Procedure (attachment K). The NPE or designee will educate current employees in all departments on OPS100 Accidents/Incidents (attachment H). Education will occur on or before 4/17/19.	

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F 689	Continued From page 19 help, and request that someone collect any tools you may need to assess the patient's condition. Call for the licensed nurse to assess the patient. Review of the facility's Fall Response Protocol (revised 5/2013 and used for patient falls) revealed that staff were to evaluate and monitor the patient, then document and investigate the circumstances. Immediate interventions included to perform an assessment for injuries and performing a neurological assessment for all unwitnessed falls and witnessed falls with head injury. Lastly, complete the fall investigation and update the care plan to reflect new interventions. Review of the facility policy entitled Falls Management (revised 3/15/16) revealed, "Patients will be assessed for fall risk as part of the nursing assessment process. Those determined to be at risk will receive appropriate interventions to reduce risk and minimize injury. . . Patients experiencing a fall will receive appropriate care and investigation of the cause." The Purpose: To reduce risk for falls and minimize the actual occurrence of falls; to address injury and provide care for a fall. Practice Standards within the policy included, "Communicate patient's fall risk status to caregivers.. . Develop individualized plan of care. . . Review and revise care plan regularly. . . If patient falls.... update care plan to reflect new interventions." 1. Review of R18's record revealed: 4/7/18 - R18 was admitted to the facility to the secured Dementia unit with multiple diagnoses including Parkinson's disease and unspecified dementia without behavioral disturbance.	F 689	D. The Center Executive Director (CED) or designee will complete audits on all resident falls (attachment L), including investigations/witness statements, clinical documentation and care plan initiation/revision during morning clinical meeting until 100% compliance on 3 consecutive reviews. Then audits will be completed weekly on all falls until 100% achieved on 3 consecutive reviews, then 20% of falls monthly until 100% compliance achieved on 2 consecutive reviews. Results of audits will be presented to the QAPI Committee for review & recommendations.	

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F 689	Continued From page 20 4/7/18 - A care plan, developed for being at risk for falls related to dementia and Parkinson's disease and included a goal that stated, "Resident will have no falls with injury for 90 days." Interventions included: Place call light within reach while in bed or close proximity to the bed; Maintain a clutter-free environment in the resident's room and consistent furniture arrangement; When resident is in bed, place all necessary personal items within reach; Monitor for and assist with toileting needs; and Bed rails to bed for enabler (to assist with repositioning by giving R18 something to hold onto). 4/7/18 - A care plan was developed for "Resident is at risk for complications due to diagnoses of Parkinson's Disease," included a goal that R18 would have no complications of Parkinson's Disease. The interventions included administer medications as ordered and assess for effectiveness and side effects and report abnormalities to physician; and monitor labs and report abnormal labs to physician. Neither care plan included monitoring of R18's gait (posture when walking) and/or mobility (ability to move or be moved freely and easily) or to monitor safety. Parkinson's disease can affect gait and mobility. 4/8/18 - A care plan was developed for impaired / decline in cognitive function or impaired thought process related to dementia and Parkinson's Disease. Interventions included: Create a calm, soothing environment by using dim lighting, reducing noise, limiting number of people, and reducing clutter.	F 689		

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F 689	Continued From page 21 4/12/18 - A fall assessment reflected that R18 had a score of 12, a "high fall risk". 4/13/18 - The Admission MDS reflected the following: R18 was assessed with a Brief Interview for Mental Status ("BIMS") score of 4, representing severe cognitive impairment. R18 was occasionally incontinent of urine without a toileting program in place. R18 was able to transfer, walk in room and in corridor independently. R18's locomotion on the unit was described as being independent using a cane/crutch. R18 did not have any falls in the last six months. 4/17/18 - A care plan, developed for "Resident is occasionally incontinent of urine with potential for improved control or management of urinary elimination related to dementia", included a goal that R18 will demonstrate improved urinary elimination control as evidenced by experiencing fewer episodes of incontinence. Interventions included: Complete a voiding diary and evaluate for patterns of incontinence at appropriate intervals; Discuss and plan voiding schedule with resident; and Provide access to the bathroom. There were no revisions made to this care plan during R18's stay at the facility. 7/6/18 - A progress note stated that R18 had a history of falls (5/3/18, 5/10/18, 7/5/18, and 7/6/18). 7/6/18 - R18's medical diagnosis listing was amended to include repeated falls; difficulty in walking and reduced mobility. 7/6/18 - A significant change MDS reflected that R18 continued with severe cognitive impairment	F 689		

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F 689	Continued From page 22 and was frequently incontinent of urine and always incontinent of bowel without a toileting program in place. R18 required extensive assistance for transfers with one person physical assist and was able to walk in his/her room and the corridor with supervision. Locomotion on the unit required supervision and mobility devices used were listed as walker and wheelchair. Review of change of condition notes and facility event summary reports described R18's falls: 7/24/18 at 11:40 AM - R18 was witnessed sliding off the mattress and landed on his/her buttocks. Staff were not able to prevent the fall. R18's cognitive/behavior factors before the fall revealed that R18 was "alert, confused, poor safety awareness". The root cause of the fall was "resident slipped out of bed" and the corrective action was a low bed and fall mat(s). A recommendation by the Primary Clinician was to monitor R18 for transfers. It was unclear how R18 was going to be monitored for transfers. 7/28/18 at 3:00 AM - R18 had an unwitnessed fall; R18 slid out of bed onto the floor. Later, R18 stated he/she was trying to use the bathroom and was confused after the roommate turned the lights on and off during the night. The root cause of the fall was identified as the light being turned on and off by R18's roommate with the corrective action being to "monitor lighting at night." It was unclear if the facility identified that R18 fell while trying to go to the bathroom. No interventions were added to the care plan for toileting or to prevent sliding off of the bed.	F 689		

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F 689	Continued From page 23 7/30/18 - Goals under the care plan for at risk for falls were amended to include "resident will have under 1 fall per week" and the following interventions were added: bed in lowest position; chair alarm; fall mat(s); Therapy / Rehab - PT treatment 3 times per week; assist resident with bed mobility getting in and out of bed with assistance of one; remind resident to use call light when attempting to ambulate or transfer; and PT evaluation. Given R18's severe cognitive impairment, it was unlikely that R18 had the mental capacity to remember to use the call bell. Review of change of condition notes and facility event summary reports described R18's falls: 8/27/18 at 3:50 PM - R18 lost his/her balance and fell to the floor. Although this fall was witnessed by the spouse of one of the residents, there were no witness statements. R18 was transferred to the hospital for treatment of a broken wrist. The root cause was listed as "poor safety awareness, dementia." 9/21/18 at 4:20 AM - R18 had a witnessed fall at which time R18 slid onto the floor, stating that he/she was exercising. There was no witness statement or recommendations identified after this fall. 9/28/18 - The intervention to transfer R18 with the assist of 2 people was added to R18's at risk for falls care plan. 10/1/18 - A quarterly MDS reflected that R18 had severe cognitive impairment and was frequently incontinent of bowel and urine; there was a bowel	F 689		

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F 689	Continued From page 24 toileting program in place, but no urinary toileting program. R18 required extensive assistance with transfers with two person physical assist and R18 was able to walk in the room with extensive assistance with two person physical assist. Locomotion on the unit was coded as requiring extensive assistance with one person physical assist and R18 used a wheelchair for mobility. 10/1/18 - R18's fall assessment was 17, a "high fall risk". 11/8/18 at 8:00 AM - A change of condition note and event summary report reflected an unwitnessed fall at which time R18 fell in the dining room when attempting to get up out of his/her chair to use the bathroom. This resulted in R18's transfer to an acute care facility for surgery for a compression fracture in the low back. The cognitive / behavior factors before the fall were listed as "alert, confused, poor safety awareness". The root cause stated, "Resident has poor safety awareness, dementia". The facility failed to identify why R18, a resident with dementia and severe cognitive impairment, was in the dining room without adequate staff supervision. The facility failed to ensure that R18 was properly supervised, in spite of his/her increasing debility and numerous notations that R18 was confused and had poor safety awareness. A toileting program was not implemented, despite R18's incontinence issues and the care plans were not revised to reflect a need for supervision. As a result, R18 experienced 9 falls during his/her stay at the facility between April, 2018 and November, 2018. Two of the falls resulted in harm to the	F 689		

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F 689	Continued From page 25 resident with regard to the 8/27/18 broken wrist and the 11/8/18 compression fracture of the spine. Findings were reviewed with E1 (NHA), E2 (DON) and E9 (ADON) on 3/4/19 during the exit conference beginning at 2:45 PM. 2. Review of R7's clinical record revealed: 6/27/17 - R7 was admitted to the facility with multiple diagnoses including dementia, severe vision impairment (blind in one eye and other eye can see shadows / light) and history of a stroke. A variety of care plans were developed for R7: - 7/19/17: Being at risk for falls related to cognitive loss, lack of safety awareness and vision impairment. Fall prevention interventions included: When in bed place all necessary personal items within reach; Monitor for and assist with toileting needs; Place call light within reach while in bed and in close proximity to bed; Provide verbal cues for safety and sequencing when needed. Additional interventions added: 2/9/18 - Supervision when out of bed; 5/1/18 - Low bed; Maintain clutter-free environment in room and consistent furniture arrangement; 7/27/18 - Remind to use call light when attempting to ambulate or transfer; 10/15/18 - Continue reminders to call for assistance for transfers; 10/23/18 - R7 looks forward to going back to bed after meals. Put back to bed 30 minutes after meals; 12/19/18 - Perimeter mattress with reminder bumpers; 12/31/18 - Toileting schedule; 1/14/19 - Utilize night light in room/bathroom; 2/11/19 - assess for changes in medical, mental and pain status and report to physician as indicated; and 2/18/19 - Fall mat(s).	F 689		

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F 689	Continued From page 26 - 9/8/17: Impaired vision due to glaucoma (eye condition leading to blindness) with an intervention to enhance vision and maximize independence (large print signs on dresser drawers, adequate lighting, keep items in same location per resident request/needs). - 10/11/17: Impaired/decline in cognitive function related to dementia that included the goal that R7 will be able to make simple decisions by responding yes or no. - 7/19/18: Restorative walking program that included the goal to walk R7 100 feet daily. - 7/30/18: Sliding out of bed to the floor and sits on the floor, refuses help to get off the floor, and states is more comfortable on the floor. 1/3/19 - A Quarterly MDS Assessment revealed that R7 had moderate cognitive impairment (BIMS score 8 out of 15; borderline for severe cognitive impairment), was continent of urine, and needed extensive assistance with one staff for bed mobility, which included getting to a seated position. R7 also required extensive assistance with one staff to walk in the hallway and was unsteady and only able to stabilize with staff assistance. 7/26/18 - 2/16/19 - Review of R7's fall investigation documentation provided by the facility, progress notes and Change of Condition Evaluations revealed that R7 experienced 19 falls in approximately seven months: a. Falls	F 689		

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F 689	Continued From page 27 7/26/18 (10:40 AM) - R7 lost his/her balance and staff assisted R7 to the floor in the dining room. The root cause of the fall was identified as "poor recall, poor safety awareness, impulsive." Recommendations included to "continue to provide a safe environment." 8/5/18 (2:50 PM) - R7 was found on the floor when going to/from bathroom with the root cause identified as "poor safety awareness, impulsive." A recommendation was made to "continue to provide safe environment." 8/10/18 (1:30 AM) - R7 removed his/her body alarm and was seen in his/her doorway and fell into the hallway. R7 denied the need to use the bathroom and "just wanted to get up." The root cause was identified as "poor safety awareness." A recommendation was made to "continue with plan of care." 8/25/18 (6:45 AM) - R7 removed his/her body alarm and was found on the floor in the bathroom. The root cause was identified as "dementia, poor safety awareness, impulsive." A recommendation was made to "continue plan of action." This was R7's second fall going to the bathroom. R7 had no toileting program in place. 8/30/18 (10:00 AM) - R7 fell in the dining room while attempting to move toward his/her walker. The root cause was identified as "poor safety awareness." A recommendation was made to "supervise when out of bed", but did not include keeping R7's walker within reach. 9/14/18 (12:15 PM) - R7's alarm activated and	F 689		

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F 689	Continued From page 28 while walking to the bathroom without using the walker, R7 lost his/her balance and hit his/her shoulder on the door frame of the bathroom and fell onto his/her face/stomach. The root cause was identified as "dementia, poor safety awareness." Recommendation included to "monitor R7, remind him/her use walker or call for assistance." In light of R7's cognitive impairment, it was unclear how well R7 would remember to use his/her walker or remember to call for assistance. 9/20/18 (1:20 PM) - R7 was found on the floor in his/her room with a 7 cm left ear laceration requiring four stitches in the emergency department. The root cause was identified as "dementia, poor safety awareness." A recommendation was made to monitor R7 when out of bed. This was the fourth fall documenting that R7 was going to the bathroom without assistance. A toileting plan was not in place. 10/15/18 (7:30 AM) - R7 was found on the floor in his/her room. Documentation reflected that R7 was going to the bathroom. The root cause stated, "dementia, safety awareness." A recommendation was made to remind R7 to call for assistance. This was the fifth fall of R7 going to the bathroom; R7 had no toileting plan in place. It was unclear how well R7 would remember to call for assistance given his/her cognitive impairment. 10/19/18 (9:20 AM) - R7 was found sitting on the floor in his/her room. A recommendation stated, "continue plan of care."	F 689		

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F 689	Continued From page 29 11/3/18 (5:30 PM) - R7 fell trying to walk in the dining room. R7's feet caught on the wheels of the wheelchair. It was unclear how R7 could fall in the dining room, which was a supervised common area. 12/13/18 (6:45 PM) - R7 fell in another resident's room "trying to get into bed." R7 was to be supervised when out of bed, so it's unclear how R7 would be in another resident's room. 12/18/18 (5:55 AM) - R7 was found sitting on the floor of his/her room. It was unclear if R7 was trying to go to the bathroom. A recommendation was made for a perimeter mattress which was implemented after this fall. 12/25/18 (9:00 PM) - R7 was seen falling when trying to walk to the bathroom. A recommendation was made for a toileting program. This was the 6th fall when R7 was going to the bathroom. 1/11/19 (1:55 PM) - R7 was seen reaching for another resident's wheelchair in the dining room and slid out of his/her wheelchair onto his/her knees, then eased self to the floor. A recommendation included to "monitor for change of condition." There was no therapy evaluation to determine any measures that may minimize R7 from sliding out of the wheelchair in the future. 1/21/19 (5:30 PM) - R7 was found on the floor when trying to go to the bathroom. A recommendation included to "monitor for change of condition." This was the 7th fall when R7 was trying to use the bathroom. There was no individualized toileting plan in place.	F 689		

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F 689	Continued From page 30 2/4/19 (11:30 AM) - R7 was found on the floor next to his/her bed while trying to go to the bathroom. This was R7's 8th fall while trying to go to the bathroom without an individualized toileting plan in place. 2/10/19 (6:15 PM) - R7 was observed falling to the floor when trying to go to the bathroom. This was R7's 9th fall while trying to go to the bathroom without an individualized toileting plan in place. 2/15/19 (1:04 PM) - R7 slid out of bed onto the fall mat and R7 said he/she was about to use the bathroom. A recommendation was made to "continue with plan of care." This was R7's 10th fall while trying to go to the bathroom without an individualized toileting plan in place. 2/16/19 (8:45 AM) - R7 yelled for staff and was found on the floor on his/her stomach facing the bathroom. R7 said he/she was trying to go to the bathroom. Recommendation included to "continue plan of care, ensure glasses are within reach." This was R7's 11th fall while trying to go to the bathroom without an individualized toileting plan in place. b. Failure to thoroughly investigate falls - 10 falls without statements from staff or witnesses: 8/30/18; 9/20/18; 10/15/18; 11/3/18; 12/13/18; 12/25/18; 1/11/19; 1/21/19; 2/10/19; and 2/15/19. - 5 falls with inaccurate footwear (recorded as barefoot or unknown when staff statement included that R7 wore "grippy socks"): 9/14/18;	F 689		

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F 689	Continued From page 31 10/19/18; 12/18/18; 2/4/19; and 2/16/19. - 1 fall in another resident room that did not include the room number: 12/13/18. - 3 falls when the facility failed to identify that R7 was on a toileting program: 1/11/19; 1/21/19; and 2/4/19. - 17 falls (before 2/15/19) when the facility failed to identify that R7 was on a restorative nursing program. - 1 fall marked as witnessed when was found on the floor: 8/5/18. R7 fell seven times trying to go to the bathroom (including the 9/20/18 fall resulting in a laceration) before a toileting plan was recommended (after the 12/25/18 fall). R7 experienced five more falls while attempting to go to the toilet after the toileting plan recommendation was implemented. R7's toileting plan was not individualized. 2/12/19 - A Physical Therapy (PT) screen for wheelchair positioning was completed a month after R7 slid from the wheelchair (1/11/19) in the dining room while reaching forward. PT documented that R7 sat midline with neutral pelvic alignment, could self-propel, used a regular cushion and attempted to stand. PT stated that R7 had increased falls due to cognitive and functional decline and recommended "enhanced supervision." 2/28/19 (8:35 AM) - During an interview with E5 (UM) when obtaining R7's chart, E5 stated "our frequent faller" and R7 does not usually get hurt. When asked what strategies are in place to	F 689		

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F 689	Continued From page 32 prevent falls, E5 stated, "toileting schedule, rounds." The UM added, "I am not a CNA, so I can't help." When R7 is trying to get up I "ask him to wait" and he/she "says ok, but when I go to get help, he/she "will get up." 2/28/19 - At 8:58 AM, R7 was observed being escorted to the sofa by the nursing station after breakfast. R7 stood up at 9:00 AM and walked, with shuffling feet, not clearing the floor, for approximately 22-23 feet down the hallway toward R7's room before staff noticed. At 9:10 AM, E10 (LPN) ran from the nursing station area to R7 and assisted the resident to walk the rest of the way to his/her room. At 9:25 AM, R7 was laying in bed (low bed) with a fall mat on the floor and the wall light illuminated. R7 was not supervised when out of bed as written in the care plan. 2/28/19 (12:30 PM) - R7 was observed asleep in bed. At 12:56 PM, R7 was attempting to get up from bed. When E5 (UM) asked R7 if he/she was "ready to get up," R7 said "yes." E5 told the resident "let me get someone to help you" and E5 left the room. R7 continued to struggle to sit upright in bed, but did not achieve a seated position when E11 (CNA) entered the room at 12:59 PM and assisted R7 up to a standing position using extensive assistance to get R7 up from bed. E11 stated, "hold still and get your balance" then "you need to lift your feet" as R7 shuffled with extensive assist of 1 staff to walk to the bathroom. Immediately after using the toilet, R7 was taken to the dining room in a wheelchair for lunch. 3/1/19 (5:32 AM) - During an interview with E12 (night time CNA assigned to R7), when asked	F 689		

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F 689	Continued From page 33 what E12's role was in preventing falls for R7, E12 stated R7 "wears a clip alarm, I check on [R7] every 2 hours, [R7] will call out (to use the toilet), grippy socks and low bed." 3/1/19 (8:20 AM) - R7 was observed being wheeled to the dining room for breakfast. At 9:00 AM R7 was finishing the meal. After receiving medications at 9:04 AM, R7 finished drinking his/her coffee. After breakfast (9:20 AM) R7 began to self propel in the wheelchair out of the dining room into the hallway and headed toward his/her room. 3/4/19 (9:15 AM) - During an interview, E11 (CNA) clarified that the toileting program is every two hours, but, "can be more often with [name of resident]." The facility failed to individualize R7's toileting plan based on his/her toileting habits. 3/4/19 (10:13 AM) - E2 (DON) was interviewed to determine what was analyzed when conducting R7's fall investigations. E2 stated that documentation in the electronic record and the RMS Event Summary Report (facility incident report) were used to determine the root cause/conclusion and corrective actions. E2 confirmed the RMS Event Summary Report errors with R7's footwear and whether the resident was on a toileting program and restorative nursing program, stating they "were mine." E2 added that it has been hard to manage R7's falls since there have been times when, after taking R7 to the toilet, he/she would "get right up." The facility failed to: - supervise R7 which resulted in 19 falls from July	F 689		

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F 689	Continued From page 34 2018 - February 2019. R7 was harmed when he/she received a 7 cm laceration on his/her left ear and requiring 4 stitches at the emergency room on 9/20/18; - conduct thorough investigations to determine the root cause of R7's falls resulting in inappropriate recommendations / interventions to minimize fall risk; and - identify and implement an individualized toileting program for R7; 3. Cross refer F 684, example #2 5/15/17 (latest revision) of the facility Safe Resident Handling/Transfer Equipment Policy: Review of the policy revealed that the Sit to Stand Lift was only to be used on residents who have some weight bearing ability and head/trunk control. Review of R5's medical record revealed: 9/6/18: R5's facility face sheet revealed that he/she was admitted to the facility for rehabilitation. 9/6/18 - A nurses' note stated that a lift-transfer-repositioning evaluation was completed. Because R5 was unable to weight-bear at least 50% on one or both legs, R5 needed a total lift (mechanical lift) to transfer. 9/7/18 - Review of a Physical Therapy (PT) initial evaluation stated that R5's motor control and gross motor coordination was impaired - paralysis of bilateral lower extremities with 0/5 (no) strength. 9/23/18 6:38 PM - E24 (RN) stated in the	F 689		

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F 689	Continued From page 35 progress notes that R5's daughter approached him/her at the nurses station, stating that R5 was dropped with the sit to stand lift after lunch, the nurse never came in to assess R5, and the family was upset. The facility's follow-up investigation revealed the following: E24's (RN) statement: On 9/23/18 at 6:34 PM, R5's daughter approached me (E24) stating that R5 told her he/she slipped out of the sit to stand lift at 1:00 PM today and wanted to know why a nurse never came to assess R5. There was no documentation in the medical record and I (E24) did not get that information in report from day shift nurse... R5 stated that two CNAs had him/her in the sit to stand and he/she slipped out of it and landed on his/her bottom on one of the CNAs feet. One of the CNAs left to get a third CNA, and the three CNAs picked him/her up off the floor. E24 asked R5 if they used a hoyer lift. R5 said no - one CNA lifted under each shoulder and picked up the legs and put him/her back in bed. R5 also stated that one of the CNAs said she was not comfortable using the sit to stand and that she would never use one again- that she would only use a hoyer lift. E24 assessed R5 at this time and found no apparent injuries. 9/24/18- The facility provided education to the three CNAs involved in the fall (E14, E17 and E25) that both a fall and lowering a resident in a downward position need to be reported to a nurse immediately, so the resident can be assessed. Findings were reviewed with E1 (NHA), E2 (DON) and E9 (ADON) on 3/4/19 during the exit conference beginning at 2:45 PM.	F 689		

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F 730 SS=E	Nurse Aide Peform Review-12 hr/yr In-Service CFR(s): 483.35(d)(7) §483.35(d)(7) Regular in-service education. The facility must complete a performance review of every nurse aide at least once every 12 months, and must provide regular in-service education based on the outcome of these reviews. In-service training must comply with the requirements of §483.95(g). This REQUIREMENT is not met as evidenced by: Based on interview and review of other facility documentation, it was determined that the facility failed to complete a performance review/appraisal once every 12 months for four (E15, E16, E17 and E18) out of five sampled CNAs. Findings include: Reviewed copies of performance appraisal for requested CNAs: - E14 (CNA): hired 2/13/18 - 90 day progress report, dated 5/25/18; - E15 (CNA): hired 3/31/15 - appraisal, dated 3/31/16; none from 2017 or 2018; - E16 (CNA): hired 5/16/17 - none; - E17 (CNA): hired 12/15/15 - none; and - E18 (CNA): hired 2/23/16 - none. 2/28/19 (3:00 PM) - During an interview with E2 (DON), the DON confirmed at the time of delivering the performance appraisals that three CNAs did not have one and the latest one for E15 was from 2016. These findings were reviewed with E1 (NHA), E2 (DON) and E9 (ADON) on 3/4/19 during the exit conference beginning at 2:45 PM.	F 730	A. Evaluations were completed for E15, E16, E17 & E18 by 3/25/19. B. Current Certified Nursing Assistants' (CNA) files were reviewed by the Employee Benefits Payroll Coordinator (EBPC) & evaluations were scheduled to bring current. C. A Root Cause Analysis (RCA) was completed on 3/21/19. As a result of the RCA, it was determined that leadership education was needed on HR616 Performance Appraisal Program: Employee Policy (attachment M). Education is being provided by the EBPC on or before 4/17/19. The EBPC will now provide a monthly list to managers for evaluations due & will track completion. D. The EBPC or designee will complete 100% audit of CNA files for compliance with timely evaluations (attachment N), audit completed monthly. Results of the audits will be presented to the monthly QAPI Committee over the next 6 months for review & recommendations.	4/17/19
F 758	Free from Unnec Psychotropic Meds/PRN Use	F 758		4/17/19

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	085010	A. BUILDING _____ B. WING _____	C 03/04/2019

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F 758 SS=D	Continued From page 37 CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is	F 758		

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F 758	Continued From page 38 appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined that the facility failed to monitor for side effects of an antipsychotic medication for one (R7) out of four residents evaluated for falls. Findings include: Review of R7's clinical record revealed: Current physicians' orders for R7 included a prescribed antipsychotic medication. December 2018 - February 2019 - Review of the MARs revealed that the facility was not monitoring for side effects of the antipsychotic medication. 2/28/19 (12:13 PM) - During an interview with E10 (LPN) about side effect monitoring, E10 stated that nursing puts stickers (for the various classes of medications) on the MAR and confirmed the one for the antipsychotic was not included on the recent MARs. E10 stated, "I may have done that one." This finding was reviewed with E1 (NHA), E2 (DON) and E9 (ADON) on 3/4/19 during the exit conference beginning at 2:45 PM.	F 758	A. Side effect monitoring was added to R7. B. A review of all residents receiving antipsychotics was completed & side effect monitoring is in place. C. A Root Cause Analysis (RCA) was completed 3/21/19. A new process was developed, when completing the Psychotropic Evaluations & Behavior Rounds, the side effect monitoring will be reviewed to check that side effect monitoring is in place. In addition, licensed nurses will receive education from the Nurse Practice Educator (NPE) or designee on the side effect monitoring form on or before 4/17/19. Admitting Nurse will initiate side effect monitoring sticker for any resident/new admission receiving an antipsychotic medicine. The CNE or designee will ensure the side effect sticker is in place upon admission for all new Admissions and reviewed at clinical meeting. D. The Center Nurse Executive (CNE) or	

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F 758	Continued From page 39	F 758	designee will complete weekly audits (attachment O) on 100% of residents with antipsychotic medications until 100% compliance for on 3 consecutive reviews. Then audits will be completed monthly until 100% compliance achieved on 3 consecutive reviews. Results of audits will be presented to the QAPI Committee for review & recommendations.	
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation and investigation, it was determined that for one (East Unit) out of three nursing units the facility failed to distribute ice in accordance with professional standards for food safety requirements. Findings include:	F 812	A. The facility obtained proper equipment to ensure the sanitary distribution of ice to the residents. B. The facility will continue to use proper	4/17/19

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F 812	Continued From page 40 2/28/19 8:35 AM - An observation of the ice cart revealed that there was no ice scoop noted to be outside within a contained holder. Observation inside of the ice chest revealed a chipped Styrofoam cup for distributing ice floating in the chest that was half full of water. 2/28/19 8:38 AM - After a staff member observed that the surveyor opened the ice chest, a CNA quickly took the ice cart off of the unit. The ice cart was not on the unit for the rest of the survey, which concluded on 3/4/19. The facility failed to ensure the sanitary distribution of ice to the residents. Findings were reviewed with E1 (NHA), E2 (DON) and E9 (ADON) on 3/4/18 during the exit conference beginning at 2:45 PM.	F 812	equipment to ensure the sanitary distribution of ice to all residents. Maintenance department checked Ice Machines on other units to determine they were in working condition. C. A Root Cause Analysis (RCA) was completed on 3/21/19. It was determined that the back up plan for use of ice chest when the ice machine is being repaired, did not have proper storing for ice scoop. As a result of the RCA, proper equipment was secured to ensure the sanitary distribution of ice to the residents. Education is being completed by Nurse Practice Educator (NPE) or designee on or before 4/17/19 to all staff regarding the proper storage & distribution of ice. D. The Food Service Director or designee will complete daily observation audits (attachment P) on the ice cart until 100% compliance for proper sanitary distribution of ice has occurred on 3 consecutive reviews. Then audits will be completed weekly until 100% achieved on 3 consecutive reviews, then monthly until 100% compliance achieved on 2 consecutive reviews. Results of audits will be presented to the QAPI Committee for review & recommendations.	
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and	F 880		4/17/19

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F 880	Continued From page 41 comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the	F 880		

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F 880	Continued From page 42 circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined that the facility failed to provide a sanitary environment to prevent the spread of infection. Findings included: 1. Observations in room 104's bathroom included: 2/28/19 1:15 PM - A gray unlabeled bedpan with powder on it resting on top of the toilet seat. 3/1/19 9:00 AM - A gray unlabeled bedpan with powder on it resting on the rim of the bathtub. 3/4/19 2:00 PM - A gray unlabeled bedpan with powder on it resting on top of a box in the bathtub.	F 880	A. New bed pans were obtained for rooms 104 & 110 and labeled with resident names & stored properly to prevent spread of infection. Room 110s' toiletries were confirmed to belong to resident and labeled with resident room number. B. An inspection of all resident rooms was completed & bed pans are labeled & stored properly to prevent spread of infection. C. A Root Cause Analysis (RCA) was completed on 3/21/19. As a result of the RCA, it was identified that education was	

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F 880	Continued From page 43 3/4/19 2:05 PM - An interview with E8 (CNA) confirmed there was an unlabeled bedpan in the bathroom and then disposed of the bedpan. 2. Observations in room 110's bathroom included: 3/1/18 9:20 AM - A pink uncovered and unlabeled bedpan on the rim of the bath tub and unlabeled toiletries on the tank of the toilet and on the grab bar behind the toilet. 3/4/18 2:20 PM - Unlabeled toiletries on the toilet tank and on the grab bar behind the toilet. 3/4/18 2:25 PM - During an interview the surveyor asked E8, "What do you do with bedpans after utilized by the resident?" E8 stated, "the bedpan could be placed on the toilet or on the floor. But you should probably put a plastic bag on it." E8 confirmed that bedpans should be labeled with a resident's name. Findings were reviewed with E1 (NHA), E2 (DON) and E9 (ADON) on 3/4/18 during the exit conference beginning at 2:45 PM.	F 880	needed for nurses & CNAs on infection control & the labeling of bedpans/urinals & toiletries. Education is being completed by the Nurse Practice Educator (NPE) on or before 4/17/19. D. The Center Nurse Executive (CNE) or designee will complete daily observation audits (attachment Q) on 10% of the resident population until 100% compliance for proper labeling & storage of bedpans occurred on 3 consecutive reviews. Then audits will be completed weekly until 100% achieved on 3 consecutive reviews, then monthly until 100% compliance achieved on 5 consecutive reviews. Results of audits will be presented to the QAPI Committee for review & recommendations.	

DELAWARE HEALTH AND SOCIAL SERVICES
Division of Long Term Care Residents Protection

DHSS - DLTCRP
3 Mill Road, Suite 308
Wilmington, Delaware 19806
(302) 577-6661

STATE SURVEY REPORT

NAME OF FACILITY: Milford Center

DATE SURVEY COMPLETED: March 4, 2019

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
	The State Report incorporates by reference and also cites the findings specified in the Federal Report. An unannounced complaint survey was conducted at this facility from February 28, 2019 through March 4, 2019. The deficiencies contained in this report are based on observations, interviews, review of residents' clinical records and review of other facility documentation. The facility census first day of the survey was 125. The survey sample totaled 21 (twenty one) residents		
3201	**Regulations for Skilled and Intermediate Care Facilities**		
3201.1.0	**Scope**		
3201.1.2	**Nursing facilities shall be subject to all applicable local, state and federal code requirements. The provisions of 42 CFR Ch. IV Part 483, Subpart B, requirements for Long Term Care Facilities, and any amendments or modifications thereto, are hereby adopted as the regulatory requirements for skilled and intermediate care nursing facilities in Delaware. Subpart B of Part 483 is hereby referred to, and made part of this Regulation, as if fully set out herein. All applicable code requirements of the State Fire Prevention Commission are hereby adopted and incorporated by reference.** **This requirement is not met as evidenced by:** Cross refer to CMS 2567-L survey completed March 4, 2019: F558, F584, F585, F657, F684, F686, F689, F730, F758, F812, and F880.	Cross Refer CMS 2567-L for F558, F584, F585, F657, F684, F686, F689, F730, F758, F812, and F880.	4/17/2019
3201.9.0	**Records and Reports**		

Provider's Signature Thelma M Thayer Title CED Date 3/27/19